



RETURN TO FINANCE DEPARTMENT NO LATER THAN MONDAY SEPTEMBER 21, 2015 AT 4:00 P.M. ALL FIELDS REQUIRED

City of Waupaca Health & Vision Plan Election Form Non-Protective Service Employees

Full Name (please print) _____

Street Address _____ City _____

State _____ Zip Code _____ Phone # (____) _____

Social Security No.* _____ Date of Birth _____ Gender: ___ Male ___ Female

Indicate your decision for enrollment in the following insurance plans (Costs listed are per pay period):

Medical plan (WCA Group Health Trust/UMR \$2,000/\$4,000 Deductible):

_____ Single (\$39.63) _____ Employee + 1 (\$79.25) _____ Family (\$111.75)

Reason for Waiving Medical Coverage _____

Superior Vision plan

_____ Single (\$3.96) _____ Ee/Spouse (\$7.92) _____ Ee/Child(ren) (\$8.93) _____ Family (\$13.82)

_____ Waive vision coverage

*Dependent Information – Due to the Affordable Care Act, if you are electing medical, dental or vision coverage for your spouse and/or dependents we will need the following information:

<u>Full Name</u>	<u>Date of Birth</u>	<u>Social Security #**</u>	<u>Gender</u>	<u>Spouse/ Child</u>	<u>Coverage(s)</u>
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
_____	_____	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Vision

I authorize the City of Waupaca to make payroll deductions for applicable premiums of the plan(s) for which I enrolled on a pre-tax basis:

Employee Signature _____ Date _____